

PLACEMENT OUTLINE/ CHILD AND FAMILY HISTORY

FILE COPY

IDENTIFYING INFORMATION					
Case Name					
Case#		Log#		Print Date	
County	District	Section	Unit	Worker	Placement Date

CHILD DETAILS

County:			
Customer ID:	DOB:	SSN:	Sex:
Religious Preference		Language:	
Birth Certificate Received:	Date Applied:		
Primary Race:	Additional Race:	Additional Race:	
	Additional Race:	Additional Race:	
Native American:			
Legal Status:		Next Hearing Date/Time:	

MEDICAL INFORMATION

Medical Insurer Name:		
Policy Holder name:		
Contract#:	Group#:	Plan Code:
Medical Insurer Name:		
Policy Holder name:		
Contract#:	Group#:	Plan Code:
Present Doctor:		
Address:		
Phone No.:		
Last Physical:	Last Dental:	
<i>Current medicine and/or special medical instructions given to foster parents(s) at the time of placement:</i>		
Entered by:		Updated On:

MEDICAL HISTORY/MEDICAL NEEDS

<i>Accidents/problems:</i>	
Entered by:	Updated On:
<i>Surgeries:</i>	
Entered by:	Updated On:
<i>Hospital Treatments:</i>	
Entered by:	Updated On:

PLACEMENT DETAILS

Current Placement Date:

Living Arrangement:

DHS 3762 given to parents? _____ YES _____ NO

Foster Parents Information:

Provider#

Provider Name:

Caregiver #1

Name:

DOB:

Primary Race:

Additional Race:

Additional Race:

Additional Race:

Additional Race:

Caregiver #2

Name:

DOB:

Primary Race:

Additional Race:

Additional Race:

Additional Race:

Additional Race:

Placement Address:

Phone#:

Circumstances leading to the need for foster care (briefly explain):

Entered by:

Updated On:

Removal Conditions

Recommended Foster Home

Recommended Type of Care:

of Parents:

Coed:

CHILD ASSESSMENT

Briefly identify the child's physical development: how the child compares physically to peers his/her age/behavior development; child's adjustment to home and/or school relationships; the relationship with age-appropriate peers; relationship with siblings. Identify any special needs of the child including any immediate and significant health needs, and plans to meet those needs. List significant identifying physical information; include eye color, hair color, height, weight, complexion, birthmarks or scars.

Entered by:

Updated On:

Educational Services:

School:

Grade:

Type of Program:

Special Education Code:

Special Education Needs:

Entered by:

Updated On:

Indicate preparation for placement that was completed for the child:

Entered by:

Updated On:

Briefly describe child's physical and emotional state at time of placement:

Entered by:

Updated On:

Immediate needs and significant services to be provided to the child to meet those needs:

Entered by:

Updated On:

FC COURT HISTORY

Petition Type	Petition Date	Hearing Date	Order Type	Order Date	Legal Status
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FAMILY RELATIONSHIPS

Caretakers/Parents

Primary Caretaker:

Relationship: Sex: DOB: SSN:
Religious Preference: Marital Status:
Primary Race: Additional Race: Additional Race:
Additional Race: Additional Race:
Address:

Secondary Caretaker:

Relationship: Sex: DOB: SSN:
Religious Preference: Marital Status:
Primary Race: Additional Race: Additional Race:
Additional Race: Additional Race:
Address:

Other Parent/

Caretaker:

Siblings

Name:

Other Members

Name:

FAMILY MEDICAL HISTORY FOR BIOLOGICAL PARENTS

List any significant health issues of other biological relatives:

Entered by:

Updated On:

SOCIAL BACKGROUND-BIOLOGICAL FAMILY

Maternal

Mother Name:
Native American
Tribal Affiliations/Enrollment#
Occupation:

Paternal

Father Name:
Native American
Tribal Affiliations/Enrollment#
Occupation:

Education:	Education:
Education Type: Regular: ____ Special Ed: ____	Education Type: Regular: ____ Special Ed: ____
No. Of Siblings of Mother:	No. Of Siblings of Father
# Brothers: _____ # Sisters: _____	# Brothers: _____ # Sisters: _____
Mother's Place in Family _____	Father's Place in Family _____

Grandparents

Grand Parents Name (Marital Status)

PARENT/CARETAKER ASSESSMENT

<i>Briefly summarize the parent(s) interaction with child(ren), with each other (if applicable): the willingness and capacity of intent to change the situation that brought the child(ren) into Foster Care:</i>	
Entered by:	Updated On:
<i>Immediate Needs and significant services to be provided to the parent to meet those needs:</i>	
Entered by:	Updated On:

REASONABLE EFFORTS

<i>Briefly summarize services provided to the child and parents/guardian including in-home services:</i>	
Entered by:	Updated On:
<i>Needed services were not provided to the child, parent, guardian or custodian. Briefly estimate why:</i>	
Entered by:	Updated On:
<i>State the likely harm to the child if he/she were separated from parents, guardian, or custodian:</i>	
Entered by:	Updated On:
<i>State the likely harm to the child if he/she were returned to parents, guardian, or custodian:</i>	
Entered by:	Updated On:

EMERGENCY CONTACTS

<u>Name</u>	<u>Phone No.</u>	<u>Relationship</u>

REQUIRED SIGNATURES

Supervisor Signature: _____

Date: _____

Supervisor Name: _____

CFC Worker Signature: _____

Date: _____

CFC Worker Name: _____

Private Agency Name: _____

Agency Signature: _____

Date: _____

This information being provided to you is confidential. MCL 722.633(3), the Child Protection Law and PA 116, MCL 722.120(2), the Child Care Organization Licensing Act, prohibit the release of this information. If you have any questions regarding release of this information, please contact the child's worker listed above.